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Handle Peer Review Records Carefully to Ensure the Most Legal Protection

Most states offer legal protection to peer review records to encourage the free exchange of information necessary for assessing and improving clinician performance. However, that protection can be limited, and missteps can make that data available to plaintiff attorneys.

A solid understanding of the laws regarding peer review protection will help one gain the most benefit.

Peer review records are a good example of the interplay between the spirt of the law and the letter of the law, says **Mark J. Silberman**, JD, an attorney with Benesch in Chicago. With peer review protection laws, legislators acknowledge mistakes happen in healthcare, and clinicians need to be able to discuss them to improve performance and patient safety, he says.

> A SOLID UNDERSTANDING OF THE LAWS REGARDING PEER REVIEW PROTECTION WILL HELP ONE GAIN THE MOST BENEFIT.

"What makes this difficult is that, sometimes, lawyers are also focused on what happened. On one side, you have hospitals and doctors who want to improve. On the other side, there may be a malpractice suit," Silberman says. "If the intent is to truly evaluate, critically and constructively, what could have been done better and how we can improve, you need some legal protection for that discussion to take place with the freedom necessary to discuss the situation honestly." A big mistake Silberman sees at some

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hospitals is trying to cram things under the peer review protection umbrella that do not belong there. An example would be emails that are intended more to protect the hospital than to understand what went wrong with the patient's care.

"People communicate without understanding where the boundaries and limitations are," Silberman says. "People try to obtain protection for material that was never intended to be protected. These are communications that are not really about finding ways to improve and are more about covering yourself."

Trying to include that kind of information with protected peer review documents runs the risk of voiding the legal protection for true peer review information, Silberman says.

"Dragging that documentation in brings more attention to the rest of your peer review-protected information. I have seen people lose protection because the documents truly were in the spirit of the peer review law affording protection, but they didn't dot every I and cross every T, thus creating an opening for those records to lose protection," he says. "An example is trying to include an email that is incredibly damning and happened three weeks before the peer review process, but you try to say it was written in anticipation of the peer review process."

Know State Laws

State laws protecting the confidentiality of information in connection with medical staff peer review usually apply to physicians, but sometimes other practitioners, too, notes **Karen Owens**, JD, an attorney with Coppersmith Brockelman in Phoenix.

While state peer review statutes vary greatly, in general they require the hospital to withhold documents which medical staff committees consider and generate in peer review from discovery in lawsuits, she says.

Typically, the statutes also protect peer review participants from submitting to depositions or trial testimony.

"Of course, the theory of peer review confidentiality is that [clinicians] are best able to assess the quality of their peers' medical care and the appropriateness of their conduct, but that [clinicians] will be unwilling to undertake such assessments if their work becomes evidence in medical malpractice lawsuits, or they themselves are subject to lawsuits by [colleagues] disgruntled over their peer review efforts," Owens explains.

She cites a comment from an Arizona court that said, "Review by one's peers within a hospital is not only time-consuming, unpaid work, it is also likely to generate bad feelings and result in unpopularity. If lawsuits by unhappy reviewees can easily follow any decision ... then the peer review demanded by [Arizona statute] will become an empty formality, if undertaken at all." (*Scappatura v. Baptist Hospital of Phoenix*, 120 Ariz. 204, 210, 584 P. 2d 1195, 1201 [App. 1978]).

But Owens notes there are limits to this confidentiality, which again vary by state.

For example, materials examined in committee that originate outside the peer review process, such as one's continuing education records or academic articles or treatises, generally do not become confidential by virtue of a peer review committee viewing them, she says.

Even this exception sometimes is limited, Owens notes. In Arizona, a

malpractice plaintiff cannot simply go on a "fishing expedition" to invade a peer review committee's deliberative process. Owens explains that in *Yuma Regional Medical Center v. Superior Court*, the court disallowed discovery of treatises and articles reviewed in committee, even though such items certainly originated outside the process, because they "[revealed] that at least one participant in the proceeding considered this particular point of inquiry important." (*Yuma Regional Medical Center v. Superior Court*, 175 Ariz. 72, 76, 852 P. 2d 1256, 1260 [App. 1993]).

Other limitations on peer review may include discoverability of the dates of review, the names of committee members, the effect of the review, and the like. It is critical to know state confidentiality parameters to avoid missteps that might destroy confidentiality.

"Perhaps the most common mistake peer review participants make is the most obvious: disclosing what happened in a peer review meeting. Whether in the doctor's lounge, on the golf course, to one's spouse, or in response to request from news media, improper disclosures can effectively remove the protections otherwise in place," Owens says. "Some state legislatures or courts address this problem by declaring peer review confidentiality to be unwaivable, even if unauthorized disclosures take place."

However, that is only a partial solution. Once the information has been disclosed, plaintiff counsel have fodder for further action, Owens says. For example, loose statements about peer review-protected proceedings regularly generate defamation lawsuits, she says.

Along the same lines, careless handling of peer review-privileged documents, whether in hard copy or online, can lead to unauthorized disclosures. Silberman also warns against inadvertent disclosure of protected information through casual conversation among participants.

"I compare it to a balloon. Once it's popped, it's popped," he says. "Once that information is out there for others to know, you're not going to make it protected again."

Can Human Resources Know?

It also is important to consult state law regarding the scope of peer review confidentiality within the hospital's administration.

Generally, hospital administrators will be permitted to know the details of peer review to meet their obligations to the hospital governing board. But is the human resources department permitted to review confidential documents? "This can become an issue when [subjects of peer reviews] are employees. In some states, disclosure of quality concerns addressed in peer review amount to an unauthorized disclosure," Owens says. "If employment action is taken based on such a disclosure, it might provide ... grounds for legal action." *(Editor's Note: See the story on page 101 for suggested steps for improving the integrity of the peer review process.)*

Peer review programs can be incredibly effective in ensuring quality care is provided, systemic problems are addressed, problem healthcare professionals are dealt with properly, and improvements are made to ensure the best patient safety possible, says **Bill Hopkins**, JD, healthcare partner in the Austin, TX, office of Shackelford, Bowen, McKinley and Norton.

Those achievements are made possible largely by the legal protection afforded peer review documents, he adds.

"One of the greatest benefits of the peer review process is the protection provided by the peer review privileges that are established under either state law or federal law under the Health Care Quality Improvement Act [HCQIA]," he says. "These privileges allow for open, complete, and honest disclosure of all the facts of a situation with the comfort that this information can be discussed

openly without fear of disclosure to third parties who might want that information to attack the facility or place liability on the professionals."

However, despite how good these protections can be, they can be lost if a facility does not strictly follow the requirements of the program in the medical staff bylaws, as well as HCQIA, Hopkins cautions.

No Absolute Protection

Some may believe peer review privilege and protections are absolute, but that is no longer true, according to Hopkins. Therefore, one of the most important steps in protecting peer review records is knowing state-level policy regarding these records. Depending on the state, one may have to modify a program and how it is administered to maximize the protections available.

"Assuming that the expected peer review protections are intact in your state, then the key to maintaining maximum protections of your documents is to review the state and federal requirements for the administration of the programs and ensure that your facility follows those requirements," Hopkins says. "Failure to do so will open up the facility to having the peer review process invalidated. That will end up resulting in the records being released."

The details of how the program is administered include how documents are created for the process, how they are stored, and who can access those records.

"The peer review process cannot be confused to believe that it makes non-confidential records confidential just because they are provided to or used in the peer review process," Hopkins says. "The peer review process typically only protects documents and communications that are created for or developed as part of the peer review process. Therefore, when a facility is investigating a situation, how the investigation is conducted and who has access to the information can either ensure protection of the documents or jeopardize the protections."

State Protections Vary

The exact information protected in a peer review process will vary by state, but there also is federal protection of certain information under the federal Patient Safety and Quality Improvement Act (PSQIA), notes **Kathy H. Butler**, JD, an officer with Greensfelder, Hemker & Gale in St. Louis. Some states offer no protections.

"States that protect peer review information often protect the details obtained during the investigative process and the deliberations of the peer review bodies reviewing a particular matter in order to facilitate full and frank peer review," she explains. "Some states limit the protections to certain types of cases like claims for personal injury. The federal law has similar protections for the investigation and deliberations of adverse events. Original medical records and information that exist outside the peer review process, such as policies, are not protected."

States that instituted peer review laws may have included specific details about what steps must be taken to protect peer review information, Butler says. In some states, like Illinois, peer review must be initiated by a peer review committee for the investigation to be protected. "There have been times when an investigation began at the direction of someone outside of the formal peer review process. As a result, the peer review protection was found not to apply," Butler says. "The applicability of a peer review privilege in litigation is often challenged. It is important that providers follow the rules, appropriately document information as peer review-protected, and take the steps necessary to maintain the confidentiality of the information."

Courts Can Void Protection

Once peer review information is protected, it remains so unless a court finds that it is not. In some cases, a provider's use of the information outside the peer review process may result in a successful argument that the provider has waived the privilege, Butler says. However, there is variation among states.

Hospital leaders and medical staff leaders need to clearly understand how the peer review process works and know the steps they need to take to protect their peer review information.

"This is not as easy as it may sound, given the different roles and responsibilities for each group. The addition of the federal PSQIA has added a layer of complexity, as that law has a different set of protections for patient safety activities," Butler says. "Taking the time to create a good process with all interested constituencies will help everyone achieve their goals and avoid inadvertent issues with the peer review and patient safety activities."

The biggest mistakes regarding peer review protection are not following the process for initiation

of the peer review process, inadvertently sharing documents, or communicating about a peer review matter outside the formal peer review process, Butler says. Hospital quality leaders should review the policies, procedures, bylaws, and work streams that are used in the process to ensure the rules are followed at each step.

"Collaborating with others who participate in the peer review/patient safety activities is important to ensure the policies are implemented in a way that meets the needs of the facility while at the same time having a good process that gives the facility the best argument that the legal protection afforded by the law applies," Butler says. ■

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How to Effectively Protect Peer Review Record Confidentiality

Medical staff and hospital quality leaders can take several steps to protect the integrity of the confidential peer review process. **Karen Owens**, JD, an attorney with Coppersmith Brockelman in Phoenix, offers these suggestions:

• Know the scope of confidentiality in your state.

• Frequently remind peer review participants, including the affected clinician, of state statutory confidentiality requirements. Some medical staff leaders recite an admonishment at the beginning of every meeting. However, if this happens, ensure committee members do not simply tune out the statement.

• Number and collect peer review documents distributed in committee so those documents do not go missing after the meeting.

• Involve hospital counsel before sharing peer review information outside the hospital. Standard statements may be developed for responding to queries from other hospitals or employers, especially when a physician is either in the peer review process or has been subject to corrective action.

• If a state does not allow sharing peer review information with human resources or other hospital departments, work out an understanding of how and whether to communicate about such matters ahead of time.

• Make sure electronic communications are protected. Avoid copying emails about peer review topics to many people. Absentminded personnel may re-send those messages far and wide.

• Take action immediately when unauthorized disclosures are discovered. This may mean counseling a clinician who made loose statements, collecting documents that have been removed, pulling back emails, and more. ■

Makeup of Peer Review Committee Crucial to Success

The effectiveness of a peer review committee will be determined in large part by who is on the committee, says **Bill Hopkins**, JD, healthcare partner in the Austin, TX, office of Shackelford, Bowen, McKinley and Norton. A peer review committee is an essential part of the overall quality assurance program of a facility. If used appropriately, this committee can be an excellent tool to evaluate patient care, identify systemic issues that may prevent good care, and weed out a problem professional. "It is important for a facility to remember that a peer review process is only as good as the people who are administering it. Facilities must strive to ensure that there is comfort, professionalism, and trust in the peer review process. Otherwise, it will not be utilized. More importantly, if the process is deemed to be corrupt, there will be

no credibility in participation in the process or the results derived," Hopkins says. "To this end, an appropriate peer review process has to work to ensure that the appropriate types of professionals are appointed to the peer review committee. Sometimes, the demographics of the members is defined by state statute. Often, it is ... defined by the facility."

The makeup of the committee is the first indication to the staff of whether the facility takes the peer review process seriously, Hopkins says. If the committee membership appears stacked or biased, the process will never be respected.

The committee membership must reflect a balance of diversity, expertise, and availability. If the committee is run well, it will produce great information. Staff will trust the process to improve the care provided in the facility. If the committee is not effective in achieving these goals, then an analysis must be performed to figure out why it is not working.

"Often, it is either the membership of the committee or the failure of the committee to strictly follow the requirements of the committee," Hopkins explains. "If it appears that the committee does not follow the rules, there can be no confidence or assurances that the appropriate outcome will be achieved based on the facts."

A quality leader's role regarding peer review is to be a "good shepherd" to the organization, composition, and direction of the peer review "flock," says **Michael F. Ruggio**, JD, partner with Nelson Mullins in Washington, DC. The peer review committee should be as small as possible, with diverse members focused on the integrity and transparency of the peer review process. Ruggio says quality leaders should use peer review committees to ensure validity of the care and the services provided, including careful research in cases. Valid care is safe care, which reduces risk for patients. Also, peer review committees can provide valuable feedback to the institution to help develop new rules or revise existing guidelines where needed.

"The quality leader needs to set up guidelines to ensure the peer review process is appropriate and that it requires review of situations that arise," Ruggio says. "It should not be used as a tool for any internal or external political, personal, or other unwarranted scrutiny." ■

SOURCE

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Impaired Clinicians Need Attention Now More Than Ever

The burnout and additional stress brought on by the COVID-19 pandemic may be leading more clinicians to abuse alcohol and drugs. It is critical that quality and peer review leaders be on the lookout for such impairment.

Conditions have combined to create an elevated risk of impaired clinicians, says **Jay Kaplan**, MD, FACEP, medical director of care transformation at LCMC Health in New Orleans.

The stress related to COVID-19 is just the latest factor that has many clinicians looking for relief in unhealthy ways. One of the biggest stressors has been the adoption of electronic health records (EHR) that require constant attention, even during off-hours, Kaplan says.

One study revealed physicians spend 90 minutes tending to the EHR after clinic hours, usually at home in what they called "clinical pajama time."[1]

The authors of other papers examined how EHR requirements may negatively affect nurses and their abilities to structure workflows and communicate with colleagues effectively.[2,3]

COVID-19, piled on top of EHR requirements and other everyday stresses, means quality professionals should be on high alert for any signs of impairment, Kaplan says. When the pandemic started, Kaplan visited with physicians, other clinicians, and staff to help assess their ability to cope with the challenges of the pandemic.

"I heard a lot about feelings of fear, frustration, and anger," Kaplan says. "I told them that if they needed to just go to a closet for a few minutes and cry, there was nothing wrong with that. They could just tell their colleagues they would be gone a few minutes, but they would return. The other thing I did was to make them aware of all the resources we offer in terms of help for people under this kind of stress, reminding them we are on their side, and encouraging them to reach out if they need help."

It is important to be proactive in reaching out to clinicians, either as a group or individuals, Kaplan adds.

One challenge with COVID-19 is the stress continues, with no end in sight, as opposed to a crisis like a hurricane or a violent incident at the hospital, Kaplan notes. The pandemic also affects the clinicians' families, whereas the home should be a respite from the stresses of work.

"I talked to one physician whose 14-year-old son had always been the golden child, but the isolation from the lockdown was causing him to act out in bad ways. In addition to everything at work, [the clinician] had to go home to that because the virus was affecting every part of his life," Kaplan says. "Another had lost five close friends to COVID, and nobody knew that. A nurse manager told me that her brother had been laid off, and their two-income home had become a one-income home."

LCMC Health has developed a peer support or "second victim" response program with experts trained in psychological first aid who can spot people in trouble, directing them to the available resources for help.

Kaplan predicts that when the COVID-19 crisis passes, there will be more cases of not only substance abuse issues but also post-traumatic stress disorder among clinicians. Thus, the importance of instituting peer support response programs now.

"Whether it's from the isolation, the way people's lives changed, and all the ongoing stress from how the pandemic is changing the business side of medicine, there are so many stressors, and [clinicians] are human. They sometimes react to stress in less-than-ideal ways, just like everyone else."

LCMC Health recently hosted a town hall-type event in which it demonstrated how clinicians can access the employee assistance program. Clinicians may be conditioned to not appear "weak" in front of others. This can lead to clinicians closing off their emotions from others, retreating to isolation and substance abuse. "We need to emphasize that, especially in these times, seeking emotional support should be considered a healthy response to everything going on around us," Kaplan says.

Look for Burnout Signs

Recognizing when healthcare providers need help is the first step, says **Tasha Holland-Kornegay**, PhD, LPCS, a licensed counselor and founder of the platform Wellness In Real Life, which assists healthcare providers who are looking to destress.

One of the main stressors that cause healthcare professionals to turn to alcohol or drugs is burnout, she says. It is one thing to know what the major symptoms of burnout are, but spotting how they manifest in a work environment is different, she says. This is especially difficult in environments that view exhaustion as a weakness.

"Many healthcare environments are infused with this type of perfectionism and workaholism. This creates a toxic workplace culture in which employees don't feel comfortable discussing their symptoms," Holland-Kornegay observes.

Symptoms such as emotional exhaustion, physical exhaustion, and negative thinking are hard to spot in others, especially if they are actively hiding it, Holland-Kornegay says. The key things to look for are cynical attitudes about oneself or others, keeping oneself isolated from co-workers, and shortness with patients, along with any other suggestion of mounting inner struggles.

"At the end of the day, without creating a more accepting workplace culture, healthcare facilities won't have the luxury of preventing burnout," she cautions. "They'll have to deal with curing it after the fact."

Preventing burnout in health facilities will entail a broad redefining of workplace culture, Holland-Kornegay says. Stress, fatigue, and exhaustion need to be more widely accepted as real issues rather than signs of weakness that should be "powered through," she

says. When workers are burned out, they need to relax and recharge.

"Working harder to power through it will just dig a deeper hole," Holland-Kornegay says. "The best intervention is to solve it at the root. When that isn't possible, establish wellness policies and places for co-workers to meet up, talk, and relax."

Superheroes Still Are Human

The public's belief that a lot of healthcare professionals are "superheroes" who operate on a higher level and do not fall victim to vulnerabilities and fragility actually can increase the risk of substance abuse and other impairments, says **Bill Hopkins**, JD, healthcare partner in the Austin, TX, office of Shackelford, Bowen, McKinley, and Norton.

"The reality is that while they do incredible lifesaving acts and operate under tremendous amounts of stress, they are actually very human, make mistakes, and sometimes succumb to the same temptations that happen to the rest of us," Hopkins says. "What often makes this temptation so much worse for healthcare professionals is that while we might have a stressful day and reach out for a bottle of alcohol or a smoke, for healthcare professionals, that temptation might lead them to look at the incredible access they have to really powerful medications."

Based on their need to be able to work and function at a high level, the impaired healthcare professional can be difficult to discover, Hopkins says. They know and understand the potency and effectiveness of medications. Clinicians can quickly figure out their tolerance and limitations that will not only give them the relief they need, but also allow them to continue to function and work.

"Much like the regular drinker, who convinces himself or herself that they are OK to drive, the healthcare professional becomes equally talented at convincing himself or herself that they are not impaired or adversely affected by their self-medication," he says. "This 'functional' impaired professional can be very hard to spot."

Added to this, the professional may become convinced he or she "needs" the medication to either cope with the stress, the pain, or the hours of the job. There may be no consideration to work without it, Hopkins says.

Since he or she figures out the "right balance" of medication, the impaired professional does not appear to be in an altered state without some significant scrutiny. The best way for a facility to discover the impaired professional is to create a culture of trust where all the employees recognize they are empowered and expected to protect the dignity and integrity of the facility, Hopkins says.

"This culture is one that illustrates that no one individual is more important than the goals of the facility and taking care of the patients. With this kind of culture, everyone is far more likely to pay attention to any actions of fellow employees. If concerns are raised, either confront the professional or utilize the systems in place to address the concerns," Hopkins says.

"Too often, when facilities do not have this type of culture, the impaired healthcare professional is protected and covered for because he or she is deemed too important to confront," Hopkins continues. "The proper consideration for patient safety is ignored, because nothing adverse has ever happened before."

Impairment Often Overlooked

Typically, in this type of scenario, the impaired professional is not discovered until he or she becomes sloppy and either makes a mistake or appears so impaired that it cannot be ignored, Hopkins says. Often, the first signs of impairment are behavioral, not clinical.

"If people are educated to pay attention to that kind of stuff, the flags tend to get raised a lot faster. Even though misappropriation of medications is not required for the truly sophisticated impaired healthcare professional, another strategy for discovery of impairment is to make sure that the auditing systems are in place to discover when a healthcare professional might be so desperate for medications that they steal them from the patients and the facility," Hopkins says. "Having effective auditing systems will raise a flag when these medications are missing and hopefully address it before a pattern is developed that defrauds the facility and, more importantly, may deny a patient much needed medication."

Once a healthcare professional is discovered to be impaired or appears to be struggling with chemical dependency issues, a facility must confront the professional to confirm the depth of the problem.

From there, leaders can determine if other actions may need to be taken. This might include medication audits and a review of patient records to make sure the proper protocols have been followed during this impairment period.

Next is the question of how to deal with the professional. Fortunately, most states, in affiliation with the license process, have set up programs to address impairment issues of healthcare professionals, Hopkins notes.

Instead of referring the healthcare professional to a standard rehab program or the licensure board, these programs are specifically designed to address the professional's chemical dependency issues.

Also, by enrolling in such programs, this maximizes the likelihood the professional can continue working, albeit under specific limitations and/or restrictions. These programs also incorporate requirements for drug testing, counseling, and therapy, so the healthcare professional's mind can heal along with his or her body. "If a healthcare professional is dedicated to getting better, then these programs are very effective and offer a path to get the healthcare professional back to work safely, while also guaranteeing patient safety," Hopkins says. "If these programs are not an option, then there really is no alternative but to refer the healthcare professional to his or her licensure board. Depending on the board, they may have the ability to provide some of the rehabilitative care similar to that found in those impairment programs." ■

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Medication Reconciliation Improved with Artificial Intelligence and Electronic Health Record

Covenant Medical Center in Saginaw, MI, recently used artificial intelligence (AI)-driven technology to protect staff and improve the quality of care for patients in its emergency care unit, completely automating the medication reconciliation process.

Previously, medication reconciliation required a pharmacy technician to interview patients face to face about their medication history, explains **Rebecca Sulfridge**, PharmD, clinical pharmacist specialist in emergency medicine at the hospital. That process became more difficult with COVID-19, as it was not practical for a pharmacy technician to interact closely with so many patients — sometimes dozens per day.

"My technicians typically are not trained on the use of personal protective equipment [PPE], and

we had a shortage of that gear, too. At first, when COVID-19 hit, it was hard to tease out the people who might be sick and at highest risk of exposing our technicians. We had to wear PPE in every room with every patient," Sulfridge shares. "That created a real barrier for our technicians to be able to do their jobs the way they did it prior to COVID-19." The pharmacy technicians also relied on calling physician offices and pharmacies to gather information about a patient's medications. Still, face-to-face interviews were a vital component that could not be skipped without replacing it with another way to gather data.

Sulfridge and other hospital leaders studied ways to change the workflow for medication reconciliation. They decided to integrate a software solution into its electronic health record. (Covenant Medical Center used technology from DrFirst, headquartered in Rockville, MD, but similar products are available from other manufacturers.) The software solution gathers information on medications during the intake process, using AI to probe for the most complete information, and compiles it in the electronic health record (EHR), asking many of the same questions that the pharmacy technicians would ask but eliminating the need for another employee to be exposed to the sick patient.

"We had the technology available to us prior to COVID-19, but we had not implemented it on any scale for medication reconciliation," Sulfridge says. "By implementing it as the primary way we do medication reconciliation, our technicians were able to see more patients, and we were still able to offer this important service to the medical center."

The technology solution has provided medication reconciliation results consistent with the previous face-to-face interviews, Sulfridge adds. In addition to reducing the exposure to patients during the pandemic, the technology has saved staff 10 minutes or more per patient, Sulfridge reports. Even if the hospital returns to some level of face-to-face medication reconciliation when the virus risk is lower, the success of the technology probably will result in some workflow changes to make the process more efficient.

"Changing workflows is always scary. When you have an established workflow that works, it's not always easy to ... make that change, to say we're going to do something different to try to get the same result," Sulfridge says. "We did that, and we're happy with the results. I'd suggest people not be afraid to use technology to your advantage to reduce how much time you're spending in a patient room." ■

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CMS Identifies Telemedicine Quality Tracking Measures

The Centers for Medicare & Medicaid Services (CMS) is providing more detailed guidance for how healthcare providers should report electronic clinical quality measures for telehealth encounters. A total of 39 electronic clinical quality measures (eCQMs) were recently published for the 2021 performance period.[1]

Any eligible professionals or eligible clinicians participating in CMS quality reporting programs for the 2020 performance period can use these updated telehealth-eligible CQMs for the Merit-based Incentive Payment System and Advanced Alternative Payment Models, Comprehensive Primary Care Plus, Primary Care First, and the Medicaid Promoting Interoperability Program for Eligible Professionals, according to CMS.

CMS notes "there may be instances where the quality action cannot be completed during the telehealth encounter by eligible professionals and eligible clinicians. Specifically, telehealth-eligible CPT and HCPCS codes may be included in value sets where the required quality action in the numerator cannot be completed via telehealth." It is the eligible professionals' and eligible clinicians' responsibility to make sure they can meet all other aspects of the quality action "within the measure specification, including other quality actions that cannot be completed by telehealth," CMS says.

CMS has identified 50 telehealth-eligible CQMs and 42 telehealth-eligible eCQMs for clinicians for 2020 performance period reporting, says **Lauren Patrick**, president of Healthmonix, a healthcare analytics company based in Malvern, PA. These are measures that represent

quality actions that can be performed remote to the patient, Patrick explains.

Some examples of these measures include Advance Care Plan, Pneumococcal Vaccination Status for Older Adults, Documentation of Current Medications in the Medical Record, Screening for Depression and Follow-Up Plan, and Controlling High Blood Pressure.

These are quality measures that existed prior to the COVID-19 pandemic and were developed to include telehealth visits in their patient population. Because of the shift to telehealth in 2020, there has been a renewed interest in understanding which measures can and should be tracked for these visits.

"Healthcare providers and organizations have exponentially increased the use of telehealth in their practices during the public health emergency brought on by COVID-19. Since they are required by the QPP [quality payment program] to report quality measures, [providers] need to understand which measures are relevant to these telehealth visits," Patrick says. "Many of the quality measures require the inclusion of telehealth visits in their reporting. Providers need to understand this, and work to ensure that these quality actions are met in the telehealth visits."

If the quality measures are not met during telehealth visits, they will negatively affect the providers' quality score in the QPP and other quality and value-based programs, Patrick cautions.

Telehealth visits cannot be excluded in the quality measure reporting. They will be scored as "quality not met" when they are not handled during these visits. Telehealth visits need to conform to standard clinical workflows and patterns of care. This new modality of patient care needs to incorporate all aspects of the established in-patient visits that can support the quality measures.

It is important to ensure quality measure actions are included in the workflows for telehealth visits, just as they are included for in-person visits, Patrick says.

"The ultimate purpose of any medical care is to maintain or improve health and well-being. Thus, how clinical applications of telemedicine affect the quality of care and its outcomes is a central evaluative question, as it is for any health service," she says. "CMS should continue to evaluate and evolve quality measures to reflect and reinforce new technology that can assist in patient care. Note that if we find that quality is trending downward when viewing telehealth visits, this could be used as an argument to reduce telehealth visits." As a point of reference, Patrick notes that when studying quality data in years past and comparing the performance against in-person visits, one could see a significant decrease in the performance of those measures. "It can be difficult to ensure that these quality measures are met as providers transition to telehealth workflows and/or the patients are remote," she says. "Ensuring that the quality actions and documentation of such are included in the workflows for telehealth visits provides a path to better performance." ■

REFERENCE

1. Centers for Medicare & Medicaid Services. Telehealth guidance for electronic clinical quality measures (eCQMs) for eligible professional/eligible clinician 2020 quality reporting. https://bit.ly/2BGIP3w

SOURCE

- **Lauren Patrick**, President, Healthmonix, Malvern, PA. Phone: (888) 720-4100.

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes;
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general;
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

COMING IN FUTURE MONTHS

- Hospital improves stroke treatment measures
- CPR training overhauled, outcomes improved
- Preparing for an accreditation survey
- Responding to accreditation insufficiencies

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CE INSTRUCTIONS

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CE QUESTIONS

1. **What happens when the Centers for Medicare & Medicaid Services (CMS) telehealth quality measures are not met during telehealth visits?**
   a. They will negatively affect the providers' score in the Quality Payment Program (QPP) and other quality and value-based programs scored as "quality not met."
   b. They will not negatively affect the providers' score in the QPP and other quality and value-based programs, scored as "quality indeterminate."
   c. CMS will note the lack of telehealth quality measures for a six-month period, and then penalize the provider if they are not met afterward.
   d. CMS will provide a three-month grace period, and then retroactively penalize the provider if the quality measures are not met afterward.

2. **Which federal statute offers protection of certain peer review information?**
   a. The Health Insurance Portability and Accountability Act
   b. The Patient Safety and Quality Improvement Act
   c. The Hospital Readmissions Reduction Program
   d. The Healthcare Quality Improvement Act

3. **What is one common mistake regarding the legal protection afforded peer review documents?**
   a. Trying to claim peer review protection for documents that do not legitimately fall under that umbrella
   b. Waiting too long to exercise a claim of peer review protection
   c. Claiming too many documents for peer review protection
   d. Declaring that a document includes peer review protection, and then trying to use it for the defense in litigation.

4. **Why can it be difficult to spot impaired clinicians?**
   a. They figure out the "right balance" of medication to not appear impaired.
   b. They tend to be extraordinarily good at lying.
   c. They ask colleagues to cover for their failings.
   d. They intimidate other clinicians and staff who may otherwise report their suspicions.